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The Clinical Utility of the Adult Attachment Projective Picture System: A Clinician's Perspective

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Running head: CLINICAL UTILITY OF THE ADULT ATTACHMENT PROJECTIVE

Abstract

The Adult Attachment Projective Picture System (AAP) is the first performance-based measure of adult attachment to be developed. The purpose of the measure is to provide a clinical understanding of an adult client's attachment status and associated coping mechanisms. The AAP is a relatively new measure that has yet to be examined from a utility perspective. In the current study, seven psychologists completed a structured survey in order to identify their perspectives of the AAP and its utility as a clinical instrument. A phenomenological qualitative analysis of the data was conducted to derive themes about the AAP and its clinical utility. Analyses aimed to answer the following: What clinical considerations do clinician's focus on when deciding to use this measure? What are common factors among clinician's who do use the measure as well as those who do not? What aspects of the measure are user-friendly and what aspects are difficult? General themes that emerged include (a) the clinical information provided by the AAP is viewed by those who use it as unique and beneficial; (b) time commitment and cost for the clinician are common considerations when clinician's are deciding whether or not to use the AAP or when pursuing training; (c) the AAP provides an increased understanding of one's relational capacities and defenses; and (d) the coding system and transcription process are difficult aspects of the AAP and influence how and/or when it is used. In addition to these themes, multiple respondents discussed potential changes for the AAP that would increase their future use of the instrument. Finally, the implications of these results are discussed.

The Clinical Utility of the Adult Attachment Projective Picture System: A Clinician's Perspective

The Adult Attachment Projective Picture System (AAP) is a set of eight picture cards that were specifically created to activate one's attachment behaviors. The measure is grounded in attachment theory, which is based on four different styles of attachment. These four classifications are one secure (Secure) and three insecure categories (Dismissing, Preoccupied, and Unresolved). These classifications parallel those used with children: Secure and three insecure categories (Anxious-Ambivalent, Anxious-Avoidant, and Disorganized). Through story telling the examinee provides a narrative that is coded for discourse (personal experience and coherency), story content, and defensive processes. Through the complex coding system, examiners are able to capture the mental representation of attachment in adults.

The goal of this study is to explore the potential advantages and limitations that the AAP can bring to clinical practice as viewed by practicing clinician's who are familiar with the measure. This is important because it will allow for those familiar with the AAP to illuminate the clinical benefits of this measure, which can ultimately improve the level of understanding in the clinician and quality of care for the client. In addition, it provides a preliminary evaluation of clinician's experiences with the measure and will result in highlighting future directions for research with the AAP that will enhance the measures overall utility.

Attachment Theory

A foundational premise to this study and to the use of the AAP in general is the belief that a child's early relational experiences, in particular those with primary caregivers, greatly influence their future relationships in adulthood. Although experiences continue through life and can shift and change patterns, early experiences seem enduring and function as a primary framework that guides relationship dynamics. As such, it is imperative to have a solid understanding of attachment theory when working with such a measure.

Attachment theory focuses on the relationships that form between a child and her/his caregivers, as well as the long-term consequences that these have on interpersonal relationships and one's view of the world. It is based on the understanding that human beings are biologically predisposed to maximize survival by maintaining a close proximity to their caregiver or protector. John Bowlby and Mary Ainsworth are two of the most prominent contributors to attachment theory and have added greatly to understanding attachment. Bowlby believed that the attachment relationship had a major impact on the person's developing personality and that it was largely determined by the caregiver's emotional responsiveness. The "internal working model" is a term frequently used to describe a person's beliefs and expectations about their caretaker and others and is born from repeated and patterned experiences. In other words, this represents how the person has internalized representations of those important caregivers. These working models remain throughout the lifespan as they become generalized and are the framework, which the person applies to future relationships. (Giannini et al, 2011; Collins, 1989)

Mary Ainsworth then began to observe the infant-caregiver relationship. In 1978, Ainsworth et al engaged in one of the first attempts at measuring attachment with the famous strange situation. The strange situation assessed child-parent attachment through direct observation of the child in the presence of the caregiver, when a stranger joined the situation, when the parent left the room, and most importantly, when the parent returned to the room. Evaluating various variables such as, proximity and closeness to the caregiver, maintaining contact, searching, and interaction assessed attachment styles. This experiment resulted in a coding system, which greatly influenced future attachment measures and included the four classifications described below. Each style reflects a mental representation of the person's view of themselves and others in relationships (Collins, 1989). These styles are thought to be closely associated with the caretaker's warmth and level of responsiveness to the child. With children, secure attachment refers to the child's solid sense of security that their caregiver will respond to their needs and their ability to utilize this caregiver as a safe person to return to in order to receive reassurance. The anxious-ambivalent classification is attributed to children who vacillate between depending on the caregiver and rejecting the caregiver's attempts to console and interact. It is thought that this results from a caregiver's unpredictability in their presence and ability to provide emotional comfort. Anxious-avoidant describes a child that is very independent of their caregiver physically and emotionally. They often avoid the caregiver and do not demonstrate distress when the caregiver is out of their sight. It is thought that these caregivers were not meeting the infant's needs. Later, Ainsworth's colleague, Mary Main, added

the disorganized attachment style. This attachment style refers to children who do not adhere to the typical activation of the attachment system and instead display disorganized behaviors and demonstrate fear behaviors (Collins, 1996).

It is a logical extension to then wonder how such styles manifest in adulthood and what impact it might have on a person's interpersonal functioning and overall level of life satisfaction. Hazan and Shafer later adapted Ainsworth's classification system in an attempt to better-fit adult relationships. Hazan and Shafer's adult classification system consisted of three classifications and included: secure, avoidant, and anxious-ambivalent. They generated and researched a list of questions used to assess characteristics of these three adult attachment styles. Later, these questions were formally integrated into the creation of the Adult Attachment Scale (AAS). After testing the AAS in further studies, they hypothesized that the AAS captures the main underlying differences in the various attachment styles (Collins, 1989).

Hazan and Shafer's research was an important early step to understanding the effects of early attachment on later adult relationships. They thought both child and adult relationships aim to achieve security. (Collins, 1989) Secure adults are thought to experience a healthy level of comfort with closeness and intimacy with others. Preoccupied (anxious/ambivalent) adults have a desire for closeness with others but experience anxieties and concerns about depending on others and the possibility of being rejected. Finally, avoidant adults are uncomfortable with closeness and depending on others altogether (Collins, 1996).

All of this information is important to the field of psychology for several reasons. The assessment of attachment can assist in the development of a treatment plan. For example, in psychotherapy the client can benefit from treatment tailored to their attachment style. Those with an insecure attachment, who struggle to accurately reflect on emotional experiences as well as to properly use mentalization, could be helped by therapeutic techniques that focus on these skills. Thus, knowing the attachment status of a client influences the therapeutic interventions chosen for particular issues and with particular clients. In addition, the client may come to view the therapist as the attachment figure. This can influence potential interpersonal behaviors that the client engages in and provide a framework for the therapist to apply when understanding their client and selecting sound therapeutic interventions. The reparative relational experience between the therapist and client can alter the existing internal working model and provide for more solid attachment relationships.

Attachment Measures

There are several measures that have been developed to assess the attachment styles of adults and children. The Attachment Story Completion Task (ASCT) is a semi-projective narrative measure used to assess attachment with children. Children are provided with story-stems and asked to complete the story. This measure allows for use of narrative as well as doll play and the use of props. These sessions are videotaped and then coded for secure and insecure attachment styles.

Additionally, projective doll play methodologies are also used to assess childhood interactions with caregivers. Play and the themes that arise from play have been a widely used therapeutic technique in child assessment and psychotherapy. Structured doll play refers to a technique in which a story-stem is provided to the child and they build from that stem the rest of the story. Story-stems are thought to elicit internal working models of attachment through the narrative provided (Woolgar, 1999). One such example is the Doll-play Interview. An Attachment Doll-play Interview (ADI) is designed to assess a child's security of attachment by allowing them to provide narratives to child-mother interactions. The ADI allows the evaluator to portray distress by enacting a story with a doll and asks the child to then create an ending to the story. The ADI measures three dimensions: the child's ability to talk about emotionally stimulating and at times conflicting themes, their ability to create stress reducing outcomes, and the quality of the child-caregiver interaction. (Oppenheim, 1997).

Once it was recognized that attachment styles continue into adulthood, efforts were made to develop attachment measures for adults. One of the most widely used measures for adult attachment is the Adult Attachment Interview (AAI), developed by Main and colleagues. This is a narrative-based interview during which individuals describe their parental relationships and share memories from their past and present relationships. The AAI yields three categories that are similar to Ainsworth's: secure/autonomous, anxious/preoccupied, and avoidant/dismissing. The questions on the AAI are designed to bring forth the individual's mental representations of early attachment experiences, in particular, experiences of

separation, and emotional and physical hurt, as well as trauma. (George & West, 2001). The AAI is described as a psychometrically sound measure by multiple authors; however, they have also identified several limitations with the measure, including the time it takes to administer, which can be between one to two hours and requiring verbatim transcription, which for an interview of that length can be onerous. In addition, the coding and classification process has been described as time-consuming, difficult, and at times costly. One particular area that the AAI did not address, that the AAP hoped to incorporate, is the ability to assess trauma.

From the AAI coding system, Kobak et al (1993) developed the Adult Attachment Q-Sort, which is an alternative coding system to use with the AAI and generates two scores on dimensions of security/anxiety and deactivation/hyperactivation. In this context, deactivation describes a level of dismissiveness and is considered a characteristic of an avoidant individual, while hyperactivation, which refers to excessive attention to detail, is more common in those who are preoccupied or anxious (Westen, Nakash, & Bradley, 2006).

In addition to narrative measures there are self-report measures that have been used to research and assess attachment. The Adult Attachment Scale (AAS), created in 1990 by Hazan and Shaver, is one such self-report questionnaire. The AAS examines adult romantic relationships and utilizes Ainsworth's classification system. It requires the individual to read 18 statements and rank on a 5-point Likert scale how characteristic they feel the statement is of them. There are three subscales that are assessed: close, depend, and anxious. The close scale measures the extent to which the person is comfortable with closeness and intimacy. The

depend scale measures the extent to which the person feels they can depend on others when needed. Finally, the anxious scale measures whether a person is concerned with being abandoned. There are several other self-report measures. The Romantic Questionnaire (RQ), Experiences in Close Relationships (ECR), and Psychological Treatment Inventory Attachment Style Scale (PTI-ASS) are examples of other such self-report measures. (Westen et al, 2006).

The Adult Attachment Projective Picture System

¹ Carol George, PhD and Malcolm West, PhD, created the AAP in an attempt to develop an easy to use and valid measure of adult attachment (George & West, 2012). It includes a coding system, which evaluates attachment constructs and processes that have yet to be assessed by other attachment measures. Historically, attachment has been assessed through observation in naturalistic settings; however, representational assessment (i.e., assessment of one's internal working models) is the "gold standard" measure for attachment.

The AAP is the first performance-based measure of adult attachment. It aims to classify each individual regarding his or her attachment style. It is a collection of pictures chosen to increasingly activate the attachment system. For each picture presented, the participant is asked to tell a story. The person uses mental representations, internal belief systems, and defensive mechanisms when interpreting the scenes. The stimuli are presented in an order that is designed to increasingly activate ones internal attachment system with the first stimulus serving

as a warm-up to the task. As such, the AAP is administered as a full set of picture stimuli and in the pre-determined order (George & West, 2012). The scenes on the AAP cards are, in order: Neutral (two children playing with a ball), Window (a child looking out a window), Departure (man and woman standing next to each other with suitcases), Bench (person sitting alone on a bench with their head in their arms), Bed (a child lying in bed reaching for a parent who is sitting on the bed), Ambulance (a woman and child watch ambulance workers load a stretcher into the ambulance), Cemetery (man standing by a gravesite), and Child in Corner (a child standing in the corner with their head turned away and arms out in front of their body), (George & West, 2011).

The images were selected to elicit the three core features of John Bowlby and Mary Ainsworth's model of attachment: activation of the attachment system, use of an attachment figure, and attachment across the lifespan. With regard to creating scenes that activate one's attachment system, scenes were chosen to depict situations that threaten one's psychological or physical safety. Regarding attachment figures, the AAP scenes include dyadic scenes, or images with two people in them, and alone pictures in which there is only one visible person. This was done under the premise that when one does not have the visible cue of a second person to regulate the attachment system they must use an internalized representation of an attachment figure. Finally, the characters depict ages from childhood through old age in order to account for variability in the representation of attachment through the developmental stages across the lifespan (George & West, 2012).

AAP administration generally takes 25 minutes and coding can take anywhere from 1 to 2.5 hours. The examiner sits across from the examinee who is handed a stimulus card and given the following instruction: "Describe what is happening in the picture, what led up to the events, what the characters are thinking or feeling, and what will happen next." These questions can be used to prompt the examinee as needed throughout their responses. Examinees are encouraged to respond freely and guided only with open-ended questions. Administrations are tape recorded, transcribed, and then coded. While generally, the AAP is completed without distress by the examinee, there are instructions to help the examiner should the examinee experience distress, become resistant, or request to discontinue (George & West, 2012).

Coding an AAP protocol focuses on the discourse, story content, and defensive processing of the narrative provided by the examinee. Within those contexts there are specific aspects assessed. With reference to discourse, the coding examines personal experience and coherency. Personal experiences reflect to what degree a person maintains a boundary between the self and the character being discussed in their story. This is deemed important because should the individual begin to make self-references in their narrative it could suggest a sense of overwhelm as a result of their attachment stress. Coherency refers to violations in quality, quantity, relation, and manner. Violations in quality include vagueness or presenting more than one storyline. Quantity violations are evident when one provides more information than necessary or by providing far too little. Relation violations occur when a person refers to their own personal history, and manner

violations encompass difficulties with constructing a narrative by using neologisms or run-on sentences. These four aspects of coherency were originally borrowed from the AAI but have been adapted to the needs of the AAP (George & West, 2001).

The next major construct evaluated by the AAP is story content. Content includes three variables: agency of self, connectedness, and synchrony. There are three aspects of agency of self: the internalized secure base, the haven of safety, and the capacity to act. The internalized secure base is the term used to describe a person's ability to utilize internal resources in order to feel content or comfortable, while the haven of safety is the term used to describe an external form of agency and when an entity, in particular the attachment figure, provides the sense of safety. Thirdly, the capacity to act is assessed because one's ability to engage in action is considered an effective strategy when the attachment system is activated. Connectedness is the second variable assessed in story content. It is a term used to differentiate between characters that are capable of and/or desire to have relationships and ones that remain alone. Lastly, synchrony refers to the evaluation of the portrayal of relationships depicted in scenes with more than one character. The interactive behaviors in these pictures are assessed and include, reciprocity, and sensitive responding (George & West, 2011; George & West, 2012).

Finally, defensive processing is an important factor incorporated into the AAP. The AAP follows Bowlby's premise of defensive exclusion and includes deactivation, cognitive disconnection, and segregated systems. Deactivation is a form of defensive exclusion that allows one to lessen or reject the importance of an attachment stimulus by shifting attention away from the stimulus that is activating

the attachment system. This tendency is characteristic of the dismissing attachment group. Cognitive disconnection is often seen with the preoccupied attachment group. It occurs when one splits attachment information into contending images or storylines. In other words cognitive disconnection exists when an individual has not integrated attachment information, which results in an inability to make confident decisions when completing the AAP. They are often mentally preoccupied with attachment experiences, which manifests in a vacillation between positive and negative emotions. Lastly, segregated systems is considered the most debilitating attachment defense and surfaces when individuals are overwhelmed by attachment trauma. This is an attempt to separate painful emotions from consciousness and often results in emotional dysregulation and attachment disorganization (George & West, 2001).

The classification system is derived from the narrative coding patterns across all stimulus cards. There is a set of predetermined classification rules one follows, which is in a decision-tree format. An individual is placed into one of four classification categories: secure, dismissing, preoccupied, and unresolved. Secure attachment is characterized by individuals who have an ability to think about attachment distress or utilize attachment figures when trying to soothe and comfort oneself. Dismissing attachment is characterized by a tendency to engage in the defensive deactivation process that allows one to maintain relational distance. Thus, distress is not well tolerated and tends to be avoided. Individuals with preoccupied attachment frequently engage in cognitive disconnection. This leads the person to focus on the affect related to the problem instead of the actual problem at hand.

Often, this affective focus is superficial and overly corrective. Finally, unresolved attachment refers to someone's difficulty in managing attachment-related fear and consequently becoming overwhelmed to the point that they cannot remain organized or effective (Finn, 2011; George & West 2011).

In order to score and interpret the AAP, a clinician must be certified as "reliable." This requires attending an eight-day training after which they must demonstrate competence by scoring a prescribed number of protocols to a certain level of accuracy. Reliable judges must complete a standardized set of 30 AAP cases with at least 80% reliability in identifying attachment classification groups. Without this certification, a clinician is not qualified to independently score AAP protocols and must send them out for scoring. Once a clinician has become a reliable judge they have the opportunity to become a master judge. Master judges are certified at a 90% match rate on AAP coding and classification challenges. This master level allows the clinician to assist those who have attended AAP training and have used the AAP clinically, but have not become a reliable judge themselves (George, 2011).

The validation of the AAP was three-pronged. The measure was initially developed from a sample of 13 men and women who had been recruited from the community. In addition to being administered the AAP, participants were also administered the Adult Attachment Interview (AAI). Transcripts of both the AAI and AAP were compared, which led to the development of the AAP's preliminary content coding dimensions. The primary goal of this initial phase was to establish concurrent predictive validity for four attachment groups (secure, dismissing, preoccupied, and unresolved) as was designated by the AAI. The reliability of AAI

and AAP scores were then assessed for interjudge reliability and this was deemed acceptable (87% agreement for four-group classifications, 97% agreement for secure versus insecure or two-group classifications, and 92% AAP/AAI convergent agreement). Then, in a larger study, involving 144 adult participants between 18 and 65-years-old, including both males and females, the AAP was examined for test-retest reliability, discriminant validity, and AAI reliability within their research design. Participants were administered both the AAP and the AAI, in varying order. A verbal intelligence measure and other questionnaires were also given to the participants. After approximately 12-weeks passed, the participants returned and completed the AAP for a second time. The results of this study indicated that there were no administration order effects and that there was a satisfactory distribution of attachment classifications. Interjudge reliability demonstrated between 85-90% agreement between judges on the four-group classifications and 92-99% concordance rates for the two-group classifications. Further, convergent agreement on the AAP/AAI was between 90-97% and test-retest reliability rates were between 62-91%. Results of this study also demonstrated that AAP classifications were not impacted by verbal intelligence or social desirability (George & West, 2001; George & West, 2012). In total, the empirical validation on this measure suggests strong support.

With regard to limitations of the AAP, there are several considerations. Basic issues include adequate vision to view the stimulus cards and the verbal abilities to provide a narrative response. In addition, each protocol is tape-recorded, which

requires the individual to consent their permission to be audio recorded. This calls for an additional area of consent and ethical considerations.

Current Study

Purpose

Given the limited information available regarding the utility of the AAP, this study explores clinician's perspectives by addressing their experiences, attitudes, and beliefs about the AAP. Analyses aimed to answer the following: (1) What clinical considerations do clinician's focus on when deciding to use this measure?; (2) What are common factors among clinician's who do use the measure as well as those who do not?; (3) What aspects of the measure are user-friendly and what aspects are difficult?

Method

Participants. A list of potential participants was developed by identifying licensed mental health clinicians who are known to have used and/or have knowledge of the AAP. Such a sample was preferred in this study because familiarity with the AAP is necessary in order for the clinician to provide informed perspectives.

The list of potential participants was based on psychologists that were known to the doctoral paper committee members for this project and specifically through a member's professional relationship with Carol George, PhD. Potential participants were members of a preexisting network of clinicians in contact with Carol George for the specific purposes of communication regarding the AAP. Several members utilize her as well as other reliable clinician's to score their AAP protocols. An effort was made to include clinicians of diverse backgrounds. Ten potential

participants were emailed information regarding the purposes of this study and information about the principal investigator and the study's faculty sponsor, as well as directions and expectations of participation. This email also included an embedded link for the participants to use that included the consent form for participation as well as the actual survey. Of the ten potential participants that were emailed, seven actually completed the survey.

Thus, seven participants were surveyed for this study, which included four from various locations within the United States and three practicing in other countries including, Canada, the United Kingdom, and the Netherlands. Of the seven (six females and one male), all were licensed mental health clinicians. Six respondents were licensed clinical psychologists at the doctoral level and one was licensed at the master's level. The range of experience spanned 24 years and included settings such as private practice, clinics, and large corporate organizations. It was especially important in this study to gauge the frequency with which these clinician's were engaged in the assessment process in order to provide context regarding the frequency that they are choosing to use the AAP and the role in which the AAP has as part of their practice. The results indicated the presence of a wide-range, with participants reporting that they performed between two to over 100 assessments within the 2014 calendar year. Of those assessments, they used the AAP between two to over 50 times. Although all clinicians had familiarity with the AAP, the levels of training across the respondents varied. Six of the seven clinician's were reliable coders, one was a master judge, and one had not attended any

formalized training. Participants were not compensated or paid for their participation.

Procedure. A structured survey was developed and disseminated to the ten participants. The survey consisted of 40 questions and took approximately 10 to 30 minutes for each participant to complete. The survey was administered and tracked through Qualtrics: Online Survey Software and Insight Platform. To maintain confidentiality, these surveys were completed anonymously and no contact information such as an email address or participant name was directly linked to the completed surveys.

The surveys were then analyzed for common themes about how frequently clinicians use the AAP, the settings in which they use the AAP, their perceptions of its potential benefits, and the utility of the instrument itself. Clinicians were also asked to identify any changes they would make to the measure regarding administration, scoring, and interpretation. Refer to the appendix for the survey questions.

Description of analysis. The phenomenological approach to data analysis lends itself well to purposes of this study. This approach is often used when trying to gather information from clinicians regarding a particular instrument. Phenomenological data analysis requires one to locate significant statements, sentences, or quotes and develop “clusters of meaning” from those themes. Those themes are then used to describe their experiences and conceptualizations regarding the concept being researched. In this study, the specific concept that was being studied was the clinical utility of the AAP (Creswell, 2006).

The author then reviewed the survey results multiple times in order to familiarize herself with the data. Throughout each review, the author took notes regarding emerging themes and concepts from each respondent. Because the results were completed electronically, the author was unable to query the responses, which limits author bias during interpretation. No further checks were used to guard against potential bias. The author then analyzed the demographic data, which included age, gender, location, degree, years of experience, and level of training with the AAP to provide context when discussing the results. Finally, the author identified themes across all responses in an attempt to address the goals of this research project.

Results

A total of four general themes emerged from the seven respondents: (a) the clinical information provided by the AAP is viewed by those who use it as unique and beneficial; (b) time commitment and cost for the clinician are common considerations when clinician's are deciding whether or not to use the AAP or when pursuing training; (c) the AAP provides an increased understanding of one's relational capacities and defenses; and (d) the coding system and transcription process are difficult aspects of the AAP and influence how and/or when it is used. All four influence how and/or when the AAP is used. In addition to these themes, the respondents reported they generally found the AAP most useful in combination with other measures and expressed satisfaction with their experiences using the AAP.

Theme 1: The clinical information provided by the AAP is considered unique and beneficial. All seven respondents indicated that the main reason they

use the AAP in their clinical practice is because of the clinical insight it provides. The clinicians collectively reported that the AAP was able to yield unique information that other measures cannot.

Of the seven respondents, three gave detailed responses describing the ways in which they find the AAP clinically useful. One respondent asserted that the AAP is best used when it can directly speak to the referral question. For example, when a person is being referred for individual therapy. Another found that the information gathered from the AAP could have a profound impact on the person in treatment. The AAP was also described as particularly useful in certain circumstances such as informing custody matters.

Theme 2: Time commitment and financial demand are common considerations when clinician's are deciding whether or not to use the AAP or when pursuing training. Although all of the respondents were familiar with the AAP, there were varying levels of training. Finances and time commitment were important considerations regarding whether or not the clinician chose to receive training and become a reliable judge. Those who chose to receive training and become reliable or master judges noted that it was beneficial to do so in order to avoid the cost associated with sending protocols out to be scored for them. In regard to efficiency, independently scoring protocols reduces the amount of time it can take to complete an assessment. On the converse, those who have not attended trainings or have not become a reliable or master judge indicated it was due to the time commitment it required.

Theme 3: The AAP provides an increased understanding of one's relational capacities and defense process. All seven respondents indicated that the AAP is uniquely beneficial because it is able to shed light on how one relates to others by elucidating their attachment styles and defense mechanisms. This happens through the stories that clients tell to the AAP cards. The very structure of the measure allows for the rare expression of these internal processes that many other measures do not accommodate. This has assisted the clinicians in a variety of ways including: leaving their client feeling understood during feedback sessions, focalizing treatment and reducing the need for additional sessions, positively impacting the clinician's level of empathy for their clients, and providing information regarding clients' abilities to provide care for others and address their own needs. Although these were identified as clinical strengths of the AAP, it was noted that it does not speak to overall intelligence, cognitive strengths or weaknesses, psychosis, suicidal ideation, reality testing, aggressive potential or impulse control.

Theme 4: The coding system, interpretation, and transcription process are difficult aspects of the AAP and influence how and/or when it is used.

Although the results were described to be unique and beneficial, the AAP has been described as labor intensive and time consuming. These two aspects are relevant to learning the coding system and interpretation as well as the transcription process. In addition, the training that is required to become a master or reliable judge was also reported to be time consuming. It was noted that all of these factors are influential when determining whether or not to use the AAP. As previously

mentioned, the time commitment also influenced a clinician not to become a reliable judge.

Additional valuable findings: This survey also assessed the respondent's attitudes and level of interest in maintaining and/or pursuing further training with the AAP. All six clinicians who were either reliable or master judges reported that following their initial attendance at an AAP training, they were motivated to become reliable. Of those six clinicians, four followed through and are now reliable judges and one is a master judge. As noted previously, time was the motivating factor not to pursue further training. The four respondents who are currently reliable judges indicated that they are interested in becoming master judges. This suggests a continued interest in the measure by those who are familiar with it and a desire to further specialize, and it also confirms positive and worthwhile experiences with the AAP. It is significant that all seven clinicians that completed the survey reported that they plan to continue to use the AAP in their clinical work at a predicted rate of at least 40% of all evaluations they project to complete.

In addition, none of the respondents endorsed using the AAP independently of other measures. Instead, they found it most helpful when used in combination with other measures. The data suggests that the AAP is especially helpful when used with other personality measures such as the MMPI and other performance-based measures such as the Rorschach. A few recorded using the AAP in combination with cognitive measures and neurological measures.

Discussion

This study allows a glimpse into how clinicians view the use of the AAP. The small sample size in this study speaks to the limited number of professionals trained as reliable or master judges and the potential opportunity for growth of its use within the field of psychology. The relatively esoteric measure has the potential to be used far more frequently, and this study illuminated aspects of the AAP that less familiar clinicians may find worthwhile. Clinicians who are experienced with the AAP provided insight regarding its perceived benefits, uses, as well as its limitations.

As discussed in the literature review, attachment has historically been assessed through observation and clinical interview. The AAP is the first measure to assess attachment with a projective or performance-based instrument that allows for mental representations to become activated. This allows for a thorough glimpse into the attachment system of the examinees in a short period of time and with a well-developed coding system. The results of such a measure can provide great benefits to the therapeutic process, in particular, the therapeutic relationship. Enhancing the treatment experiences as well as possibly reducing the length of time one is in treatment is highly attractive to consumers and will lend itself to the brief treatment approach most public mental health facilities encounter.

Participants in this study stressed the importance of the unique and beneficial clinical information that the AAP is able to yield. In particular, it was pointed out that the AAP elucidates one's relational capacities and defensive processes. This information was described as valuable because it sheds light on how

best to relate to this person in a therapeutic relationship, how to assist them in feeling understood, and in streamlining therapy.

The respondents in this study varied in their level of experience with the AAP. The majority have received training and are currently reliable judges with a few outliers who have not received training or had further training as a master judge. When discussing aspects that impacted their decision to pursue training and to which degree, several considerations were mentioned. Most important appeared to be the time commitment it requires to attend trainings and the general time commitment it requires to code a protocol. In fact, one of the participants indicated that she/he chose not to pursue training because it was too demanding on their time and sending protocols out to be scored was preferred. Despite that, several respondents suggested that the financial strain of having to repeatedly send out protocols to be scored should one use the AAP frequently was a major factor persuading them to pursue their training to be able to independently code their protocols. In regard to the general time commitment of using the AAP, it was mentioned by several respondents that it is a labor-intensive measure and this is a major factor when choosing to use it in a battery. The AAP requires verbatim transcription of every protocol administered prior to coding, followed by the coding, and ultimately the interpretation. The cost-benefit analysis of time consumption against rich clinical information appeared to be a heavily weighted factor.

The majority of research involving the AAP is structured around its development, its coding system, and how it differs from previous measures. Further

utility studies and outcome studies that assess the clinical impact of the measure would be greatly beneficial to expanding awareness around the AAP.

Limitations of Study

One major limitation to this study is that the only potential respondents included were those that were familiar to the author's faculty sponsor and their consultant. There were only ten clinicians in the potential pool of participants, which resulted in only seven total participants. This low sample size provides a limited view of clinicians' awareness, attitudes, and knowledge when compared to the larger field of psychology. However, given the study's intention to examine experiences and attitudes towards the AAP it was necessary to survey those that had a certain level of familiarity with the measure. As a result, this method of recruitment was deemed appropriate. Another limitation of the current study was the composition of the survey and the nature of surveys in general. The depth of information collected regarding the clinicians' personal examples and explanations was limited. The limited set of questions could also have impacted the quality of information collected, as was the inability to contact respondents to clarify or ask for elaborations. In addition, the themes that emerged through this survey can emerge as a function of the questions asked and limit the breadth of information or opinion.

Future Research

Given the aforementioned conclusions and limitations, future research is warranted in a variety of areas related to the use of the AAP. An important direction of future research would involve determining the efficacy of the AAP in treatment.

In particular, it would be helpful to measure short and long-term outcomes for therapy clients who have participated in the AAP to inform their treatment. This could include treatment outcomes such as symptom reduction, enhanced interpersonal abilities, client feedback, as well as the clinician's perspective.

Although the current study furnished important insights and understandings, the small and selective sample size limited the breadth of data collected. It is likely that additional information would have been gleaned with a greater number of opinions, critiques, and reflections. It would be helpful to conduct further quantitative or qualitative studies with a larger number of participants who both do and do not have familiarity with the AAP. In regard to the clinical utility of the AAP, it would be beneficial to survey clinicians who actively use the measure from a more diverse clinical setting (i.e., settings outside of private practice). In addition, conducting a cost-benefit analysis to provide quantitative data to assess if the costs warrant the benefits of using this measure would be beneficial.

Conclusion

As the structure of healthcare continues to shift and change, the impact that it has on mental health care remains uncertain. This coupled with economic variables has led clinicians to require a certain level of adaptability in their provision of treatment. As such, psychological evaluation and assessment have taken new forms as they aim to glean in-depth psychological insights in short-periods of time. One of the most fundamental purposes of the AAP is to provide a rich understanding to how one relates to others through their attachment style and the activation of their defensive processes. This information allows clinicians to

better understand and meet the client where they are currently in a shorter period of time, thus potentially decreasing the length of time necessary for one to be in treatment and enhancing the client's experience.

This study examined the clinical utility of the AAP as viewed by clinicians who are familiar with this measure, and it provided insight into how this measure is helpful, how it is best used, and what are its limitations. One conclusion that can be established from this study is that there are practicing clinicians who find this measure immensely beneficial and encourage its use. Despite that, it is not a frequently used measure, so there is significant room for future research to further understand its place within the field. The research of adult assessment has been noted as becoming increasingly important. As more attention is paid to this area it will call for enhanced research efforts, which will undoubtedly include the AAP.

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Appendix

The Adult Attachment Projective Picture System: A Clinician's Perspective

Q1 My name is Ashley Gunterman and I am a graduate student at the University of Denver in clinical psychology. As part of my doctoral degree, I am required to complete a doctoral paper, which is comparable to a dissertation. Hale Martin, PhD is the chair for this project. I am requesting participation in a very brief survey regarding the Adult Attachment Projective Picture System (AAP). The general purpose of this study is to gain insight into clinician's perspectives regarding the clinical utility of the AAP. Your experience with and knowledge of the AAP can provide invaluable information and I would greatly appreciate it. The survey should take between 10-30 minutes to complete. The informed consent is below and can also be found below each question in the survey. Should you have any questions regarding this study please feel free to contact Dr. Martin (halmarti@du.edu or myself (ashleygunterman@yahoo.com). Thank you in advance for your time and contribution!

University of Denver Information Sheet for Exempt Research

TITLE: The Clinical Utility of the Adult Attachment Projective Picture System: A Clinicians Perspective

Principal Investigator: Ashley Gunterman, M.S.

Protocol #: 567788-1

Approval Date: 11/7/2014

You are being asked to be in a research study. This form provides you with information about the study. Please read the information below and ask questions about anything you don't understand before deciding whether or not to take part.

You are invited to participate in a research study about the clinical utility of the Adult Attachment Projective Picture System (AAP). If you agree to be part of the research study, you will be asked to complete a survey disseminated to you via email. The survey includes questions about your experience with the AAP. Additional survey questions will address your perceptions of the clinical utility of this measure. In addition, certain demographic information and professional information will be collected.

There are no potential risks or discomforts associated with participation.

By doing this research we hope to learn about how the AAP is being used in the field and clinician's perspectives regarding their decisions to use this instrument. Additionally, this study hopes to collect information about what aspects of the AAP are found to be beneficial and/or difficult.

You will receive no compensation by participating in this survey.

This study is not funded.

Participating in this study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. You may choose not to answer any survey questions for any reason.

If you have questions about this research study, you may contact Ashley Gunterman, M.S. at 734-674-4637 or Hale Martin, Ph.D. at 303-871-3878.

If you have any concerns or complaints about how you were treated during research participation, you may contact the Chair of the Institutional Review Board for the Protection of Human Subjects, at 303-871-4015 or by emailing IRBChair@du.edu, or you may contact the Office for Research Compliance by emailing IRBAdmin@du.edu, calling 303-871-4050 or write to the University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121.

The University of Denver Institutional Review Board has determined that this study qualifies as exempt from full IRB oversight.

You should receive a copy of this form for your records. If you do not understand any part of the above statement, please ask the researcher any questions you have.

Agreement to be in this study

I have read this paper about the study or it was read to me. I understand the possible risks and benefits of this study. I know that being in this study is voluntary. If I choose to be in this study I will be able to print a copy of this consent form. By choosing yes below and completing this survey, I am consenting to participating in this research study.

☐ YES (1)

Q2 Gender

☐ Male (1)

☐ Female (2)

Q3 Age

Q4 Please enter your degree type:

☐ Doctorate (1) _____

☐ Master's (2) _____

☐ Student (working towards what degree) (3) _____

☐ Other (4) _____

Q5 Year you obtained your degree or the date you anticipate earning your degree

Q38 What setting(s) do you currently practice/train in?

Q6 Do you have an active clinical license?

- ☐ Yes (1)
- ☐ No (2)

Answer If Do you have an active license? Yes Is Selected

Q7 What kind of clinical license?

Q15 How many assessments have you completed in the past year? (assessments in this context are considered to be any two or more measures)

Q9 Have you used the AAP in your clinical work?

- ☐ Yes (1)
- ☐ No (2)

Answer If Have you used the AAP in your clinical work? No Is Selected

Q41 What are the reasons you have not used the AAP in your clinical work?

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q16 Of the assessments you have completed in the past year, how many have included the AAP?

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q8 Please rank order by frequency the setting in which you use the AAP

- ____ Private Practice (1)
- ____ Outpatient (2)
- ____ Inpatient (3)
- ____ Educational/Academic (4)
- ____ Other (5)

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q10 Month and year you gave your first AAP

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q11 Month and year you gave your last AAP

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q12 Total AAP's you have personally administered and scored

- ☐ 0-5 (1)
- ☐ 6-10 (2)
- ☐ 11-15 (3)
- ☐ 16-20 (4)
- ☐ 20 and up (5)

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q13 Total AAP's you have personally administered and sent for scoring

- ☐ 0-5 (1)
- ☐ 6-10 (2)
- ☐ 11-15 (3)
- ☐ 16-20 (4)
- ☐ 20 and up (5)

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q14 Total AAP's administered by another person but that you personally utilized clinically

- ☐ 0-5 (1)
- ☐ 6-10 (2)
- ☐ 11-15 (3)
- ☐ 16-20 (4)
- ☐ 20 and up (5)

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q18 What factors influence your decision to use the AAP? (clinical reasons, practice setting, time constraints, etc.)

Q19 Have you attended AAP training?

- ☐ Yes (1)
- ☐ No (2)

Answer If Have you attended AAP training? Yes Is Selected

Q20 After training, were you motivated to become a reliable judge? (individuals who attend the training are eligible for certification as an AAP judge. Certified judges must complete reliability with at least an 80% success rate for identifying attachment classification groups on a standardized set of AAP cases)

- ☐ Yes (1)
- ☐ No (2)

Answer If Have you attended AAP training? Yes Is Selected And After training, were you motivated to become a reliable judge? (individuals who attend the training are eligible for

certification as an AAP judge. Certified judges must complete reliability with a... Yes Is Selected

Q23 Are you a reliable judge?

- ☐ Yes (1)
- ☐ No (2)

Answer If Have you attended AAP training? Yes Is Selected And After training, were you motivated to become a reliable judge? (individuals who attend the training are eligible for certification as an AAP judge. Certified judges must complete reliability with a... Yes Is Selected And Are you a reliable judge? Yes Is Selected

Q21 What influenced your decision to become a reliable judge?

Answer If Have you attended AAP training

Q22 What influenced your decision not to attend a training?

Answer If Are you a reliable judge

Q24 If you are a reliable judge, are you interested in becoming a master judge? (master judges are certified at a 90% match rate on all AAP coding and classification. Becoming a master judge allows you to assist those who have attended AAP training, have used the AAP clinically, but have not become a reliable judge)

- ☐ Yes (1)
- ☐ No (2)

Answer if you are a reliable judge, are you interested in becoming a master judge? (master judges are certified at a 90% match rate on all AAP coding and classification. Becoming a master judge allows you... Yes Is Selected

Q39 What influences your decision to become a master judge?

Answer if you are a reliable judge, are you interested in becoming a master judge? (master judges are certified at a 90% match rate on all AAP coding and classification. Becoming a master judge allows you... No Is Selected

Q40 What influences your decision not to become a master judge?

Answer if you are a reliable judge

Q25 If you are not a reliable judge, do you send personally completed protocols to a reliable judge?

- ☐ Yes (1)
- ☐ No (2)

Answer If Are you a reliable judge? No Is Selected

Q26 Are you interested in becoming a reliable judge?

- ☐ Yes (1)
- ☐ No (2)

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q27 Do you use the AAP alone or in conjunction with other measures?

- ☐ Alone (1)
- ☐ In combination with other measures (2)
- ☐ Both (3)

Answer If Have you used the AAP in your clinical work? Yes Is Selected And Do you use the AAP alone or in conjunction with other measures? In combination with other measures Is Selected Or Do you use the AAP alone or in conjunction with other measures? Both Is Selected

Q28 If you use the AAP in a testing battery, what other measures do you typically use? Please rank-order based on frequency.

- ___ MMPI (2 & RF) (1)
- ___ Rorschach (2)
- ___ PAI (3)
- ___ MCMI-III (4)
- ___ TAT (5)
- ___ Cognitive tests (WAIS, WASI, etc) (6)
- ___ Neurological tests (RBANS, NAB, etc) (7)
- ___ Other (8)

Answer If Have you used the AAP in your clinical work? Yes Is Selected And Do you use the AAP alone or in conjunction with other measures? In combination with other measures Is Selected Or Do you use the AAP alone or in conjunction with other measures? Both Is Selected

Q29 If you use the AAP in combination with other measures, how useful do you generally find it to be in assisting your clinical work? This could include informing therapeutic interventions in therapy, assessment recommendations, or in clinical conceptualizations. (1 being the least helpful and 10 being the most helpful)

- ☐ 0 (0)
- ☐ 1 (1)
- ☐ 2 (2)
- ☐ 3 (3)
- ☐ 4 (4)
- ☐ 5 (5)
- ☐ 6 (6)
- ☐ 7 (7)
- ☐ 8 (8)
- ☐ 9 (9)
- ☐ 10 (10)

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q30 What unique information does the AAP provide?

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q31 If any, what information is not provided by the AAP that others measure provide?

Answer If Do you use the AAP alone or in conjunction with other measures? Alone Is Selected Or Do you use the AAP alone or in conjunction with other measures? Both Is Selected

Q32 If you have ever used the AAP by itself (not within a testing battery), how useful do you generally find it to be? (1 being the least helpful and 10 being the most)

- ☐ 0 (0)
- ☐ 1 (1)
- ☐ 2 (2)
- ☐ 3 (3)
- ☐ 4 (4)
- ☐ 5 (5)
- ☐ 6 (6)
- ☐ 7 (7)
- ☐ 8 (8)
- ☐ 9 (9)
- ☐ 10 (10)

Answer If Have you used the AAP in your clinical work? Yes Is Selected

Q33 Will you continue to use the AAP?

- ☐ Yes (1)
- ☐ No (2)

Answer If Will you continue to use the AAP? Yes Is Selected

Q34 How frequently do you anticipate using it? (1 being in rare instances and 10 being in every case)

- ☐ 0 (0)
- ☐ 1 (1)
- ☐ 2 (2)
- ☐ 3 (3)
- ☐ 4 (4)
- ☐ 5 (5)
- ☐ 6 (6)
- ☐ 7 (7)
- ☐ 8 (8)
- ☐ 9 (9)
- ☐ 10 (10)

Answer If Will you continue to use the AAP? No Is Selected

Q35 What reasons have lead you to the decision of no longer using the AAP?

Answer If Have you attended AAP training? Yes Is Selected

Q36 What aspects (materials, scoring, etc) of the AAP are easy to use?

Answer If Have you attended AAP training? Yes Is Selected

Q37 What aspects (materials, scoring, etc) of the AAP are difficult to use?